EXHIBIT 286
(Rev. 30, 12-15-07)

HOSPITAL/CAH MEDICARE DATABASE WORKSHEET

Worksheet completed by the SA surveyor to gather data *of worksheet*, not to be given to provider to fill out.

***CMS Certification* Number *(CCN)*:_____ Date *of Worksheet* Update: _____**

Medicaid Provider Number:_____ (MMDDYYYY) (M1)

National Provider Identification Number (NPI):_____

Fiscal Year Ending Date (MMDD): _____

Name and Address of Facility (Include City, State):

_____

_____

_____**Zip Code:_____**

Telephone Number (M2): _____ *Fax Number (M3):_____*

Email Address:_____

Accreditation Status:_____

0 Not Accredited

1 JC Accredited

2 AOA Accredited

4 Both

Effective Date of Accreditation: _____

(MMDDYYYY) (M4)

***Renewal* Date of Accreditation:_____**

(MMDDYYYY) (M5)

State/County Code (M6):_____

State Region Code (M7):_____

***Type of Program Participation* (M8):_____**

1 Medicare

2 Medicaid

3 Both

CLIA ID Numbers (M9):

_____

_____

_____

_____

Type of Hospital or a Critical Access Hospital (CAH) (select 1) (M10):_____

01 Short-term ___
02 Long-term ___
03 Religious Non-medical Health Care Institution___
04 Psychiatric ___
05 Rehabilitation ___
06 Childrens___
07 Distinct Part Psychiatric Hospital__
08 *Cancer Hospital*___
***11 Critical Access Hospital (CAH)*___**

Affiliation with a Medical School (M11):_____

01 Major
02 Limited
03 Graduate School
04 No Affiliation

Resident Programs (M12):_____
(select all that apply)

01 AMA
02 ADA
03 AOA
04 Other
05 No Program
06 Podiatric

Ownership Type **(select 1) (M13):_____**

01 Church
02 ***Private(Not for Profit)***
03 ***Other (specify*****:_____**
04 ***Proprietary(For Profit)***
05 ***Federal*****_**
06 ***State***
07 ***Local***
08 ***Hospital District or Authority***
09 Physician Ownership
10 Tribal

Average Daily Census (M14):_____

Number of Staffed Beds (M15):_____

Type of ***Chain/Health*** **System Involvement (M16):_____**

01 None
02 System Ownership
03 System Management
04 Both System Owned and Managed

Name of System (M17):_____

Corporate Headquarters City (M18):_____ State (M19):_____

Number of Employees Salaried by Hospital/CAH (Use Full Time Equivalents FTE)					
M20	**Physicians (Salaried only)**		**M30**	**Medical Technologists (Lab)**	
M21	**Physicians - Residents**		**M31**	**Nuclear Medicine Technicians**	
M22	**Physician Assistants (PA)**		**M32**	**Occupational Therapists**	
M23	**Nurses - CRNA**		**M33**	**Pharmacists (Registered)**	
M24	**Nurses - Practitioners**		**M34**	**Physical Therapists**	
M25	**Nurses - Registered**		**M35**	**Psychologists**	
M26	**Nurses – LPN**		**M36**	**Radiology Technicians (Diagnostic)**	
M27	**Dieticians**		**M37**	**Respiratory Therapists**	
M28	**Medical Social Workers**		**M38**	**Speech Therapists**	
M29	**Medical Laboratory Technicians**		**M39**	**All Others**	

Type of Reimbursement *or Status Categories of a Hospital or a CAH* (select all that apply) (M40):_____

01	CAH Psychiatric DPU		07	Hospital PPS Excluded Psych Unit	
02	CAH Rehabilitation DPU		08	Hospital PPS Excluded Rehab Unit	
03	CAH Swing Beds		09	Hospital Swing Beds	
04	Specialty Hospital		10	Medicare Dependent Hospital	
05	Hospital in a Hospital - Host		11	Regional Referral Center	
06	Hospital in a Hospital - Tenant		12	Sole Community Hospital	

Services Provided by the Facility (M41):_____

0 Service not provided

1 Services provided by facility staff *only*

2 Services provided by arrangement or agreement

3 Services provided through a combination of facility staff and through agreement

01	Ambulance Services (Owned)		34	Operating Rooms	
02	Alcohol and/or Drug Services		35	Opthalmic Surgery	
03	Anesthesia		36	Optometric Services	
04	Audiology		37	Organ Bank	
05	Blood Bank *- FDA Approved*		38	Organ Transplant Services	
06	Burn Care Unit		39	Orthopedic Surgery	
07	Cardiac Catheterization Laboratory		40	Outpatient Services	
08	Cardiac-Thoracic Surgery		41	Pediatric Services	
09	Chemotherapy Service		42	Pharmacy	
10	Chiropractice Service		43	Physical Therapy Services	
11	CT Scanner		44	Positron Emission Tomography Scan	
12	Dental Service		45	Post-Operative Recovery Rooms	
13	Dietetic Service		46	Psychiatric Services - Emergency	
14	Emergency Department (Dedicated)		47	Psychiatric - Child/Adolescent	
15	Emergency Services		48	Psychiatric - Forensic	
16	Extracorporeal Shock Wave Lithotripter		49	Psychiatric - Geriatric	
17	Gerontological Specialty Services		50	Psychiatric - Inpatient	
18	Home Health Services		51	Psychiatric - Outpatient	
19	Hospice		52	Radiology Services - Diagnostic	
20	ICU - Cardiac (non-surgical)		53	Radiology Services - Therapeutic	
21	ICU - Medical/Surgical		54	Reconstructive Surgery	
22	ICU - Neonatal		55	Respiratory Care Services	
23	ICU - Pediatric		56	Rehab -Inpatient (CARF Acc)	
24	ICU - Surgical		57	Rehab -Inpatient (Not CARF Acc)	
25	Laboratory - Anatomical		58	Rehab -Outpatient	
26	Laboratory - Clinical		59	Renal Dialysis (Acute Inpatient)	
27	Long Term Care (swing-beds)		60	Social Services	
28	Magnetic Resonance Imagining (MRI)		61	Speech Pathology Services	
29	Neonatal Nursery		62	Surgical Services - Inpatient	
30	Neurosurgical Services		63	Surgical Services - Outpatient	
31	Nuclear Medicine Services		64	*Tissue Bank Services*	
32	Obstetric Service		65	*Trauma Center (Certified)*	
33	Occupational Therapy Services		*66*	Urgent Care Center Services	

Sprinkler Status, Primary Location (select 1) (M42): _____

01 Totally sprinklered: All required areas are sprinklered

02 Partially sprinklered: Some but not all required areas are sprinklered

03 Sprinklers: None

***Total n*umber of off-site locations *under* the same *CCN* (M43):_____**

TYPES OF OFF-SITE LOCATIONS					
01	**Inpatient Remote Locations**		**07**	**Satellites of a PPS-Excluded Psych Unit**	
02	**Offsite Freestanding Outpatient Surgery**		***08***	**Satellites of a Long Term Care Hospital**	
03	**Urgent Care Center (Freestanding)**		***09***	**Satellites of a Cancer Hospital**	
04	**Satellites of a Rehabilitation Hospital**		***10***	**Satellites of a Childrens' Hospital**	
05	**Satellites of a Psychiatric Hospital**		**11**	**Other Provider-Based Location**	
06	**Satellites of a PPS-Excluded Rehab Unit**		**12**	Offcampus Emergency Department	

Identification Number Assigned to the Specific* Off-site Location *(from table)

***(M44)*_____**

Name of Off-site Location (45): _____

Off-site Street Address (M46):_____

***County (47):*_____**

City (M48):_____State (M49):_____ Zip Code (M50):_____

Sprinkler Status of Off-site Location (select 1) (M51):

01 Totally sprinklered: All required areas are sprinklered

02 Partially sprinklered: Some but not all require areas sprinklered

03 Sprinklers: None

04 Sprinklers are not required but the location is sprinklered

If there is more than one off-site location, complete and attach the Provider-Based Off-Site Locations Continuation Worksheet until all locations are accounted for.

Number of related or affiliated *providers or suppliers* (*M52*):_____

TYPES OF AFFILIATED PROVIDERS					
01	**Ambulatory Surgery Center (ASC)**		**06**	**Home Health Agency**	
02	**Collocated Hospitals**		**07**	**Hospice**	
03	**Collocated Satellites of Another Hospital**		**08**	**Psychiatric Residential Treatment Facility**	
04	**End Stage Renal Disease (ESRD) Center**		**09**	**Rural Health Clinic (RHC)**	
05	**Federal Qualified Health Center (FQHC)**		**10**	**Skilled Nursing Facility (SNF)**	

Identification Number of related or affiliated provider numbers (53): _____

Provider Number (54): _____

If there is more than one related or affiliated provider or supplier, attach the Related or Affiliated Provider Numbers Continuation Worksheet until all are accounted for.:

Signature of Authorized Individual:_____

***Print* Name of Authorized Individual:_____ Date:_____**

PROVIDER-BASED OFF-SITE LOCATION CONTINUATION WORKSHEET PAGE 1 OF _____

Type of off-site location and total number of each type of off-site location:

- ***Identify every location (that bills for services using the provider's Medicare CCN) of the provider that is located off the provider's primary campus/location;***
- ***In the block "Number of off-site locations with the same provider number (M43)", write the total number of off campus location; and***
- ***Place the total number of each type of off-site location in the space beside that type of location. Example: If a hospital has two additional campuses, enter the number "2" in the block beside "01 Inpatient Remote Location".***

Total Number of off-site locations with the same CCN (M43):_____

TYPES OF OFF-SITE LOCATIONS					
01	Inpatient Remote Locations		07	Satellites of a PPS Excluded Psych Unit	
02	Off-site Freestanding Oupatient Surgery		08	Satellites of a Long Term Care Hospital	
03	Urgent Care Center (Freestanding)		09	Satellites of a Cancer Hospital	
04	Satellites of a Rehabilitation Hospital		10	Satellites of a Children's Hospital	
05	Satellites of a Psychiatric Hospital		11	Other Provider-Based Locations	
06	Satellites of a PPS Excluded Rehab Unit		12	Off Campus Emergency Department	

- ***Complete an identification entry for each off-site location that bills for services under the provider's CCN. Example: If a hospital has seven off-site locations that bill for services under the hospital's CCN, complete seven separate entries;***
- ***Complete all the blocks for each off-site location;***
- ***From the table above, enter the identification number for the type of off-site location. Example: Enter "02" for an off-site freestanding outpatient surgery location; and***
- ***Using the Code number provided, enter the sprinkler status of each location.***

ENTRY _____
Identification Number Assigned to the Specific Off-site Location (from table) (M44): _____
Name of Off-Site Location (M45):_____
Off-Site Street Address (M46): _____
County (M47): _____
City (M48): _____State (49):_____ Zip Code (M50):_____
Sprinklered Status of Off-site Location (select 1) (M51): _____

01 Totally sprinklered: All required areas are sprinklered;
02 Partially sprinklered: Some but not all required areas sprinklered;
03 Sprinklers: None; or
04 Sprinklers are not required but the location is sprinklered

ENTRY _____
Identification Number Assigned to the Specific Off-site Location (from table) (M44): _____
Name of Off-Site Location (M45):_____
Off-Site Street Address (M46): _____
County (M47): _____
City (M48): _____State (49):_____ Zip Code (M50):_____
Sprinklered Status of Off-site Location (select 1) (M51): _____

05 Totally sprinklered: All required areas are sprinklered;
06 Partially sprinklered: Some but not all required areas sprinklered;
07 Sprinklers: None; or
08 Sprinklers are not required but the location is sprinklered.

Make additional copies as needed for additional off-site locations.

RELATED OR AFFILIATED CCN CONTINUATION WORKSHEET PAGE 1 OF_____

Identify all related or affiliated Medicare or Medicaid providers/suppliers that are:

---Owned and/or operated by the hospital or CAH; or
---Located on a campus or location of the hospital or CAH; and
---Do not bill for services under the hospital or CAH CCN.

- ***In the block "Number of related or affiliated provider/suppliers (M52)", write the total number of all related or affiliated providers/suppliers. Example: If a hospital has 1 collocated hospital, 1 hospice, and 1 SNF to which it is related or affiliated, the number "3" would be entered.***

- ***In the block beside the identified provider/suppliers, write the total number of that particular provider/supplier type that is related or affiliated to the hospital/CAH. Example: If a CAH has one provider-based RHC, enter the number "1" in the block beside "09 RHC"; if a hospital has two affiliated Medicare certified ASC which have their own CCN, enter the number "2" in the block beside "01 ASC"***

TYPES OF AFFILIATED PROVIDERS/SUPPLIERS					
01	***Ambulatory Surgery Center (ASC)***		**06**	**Home Health Agency**	
02	**Collocated Hospitals**		**07**	**Hospice**	
03	**Collocated Satellites of Another Hospital**		**08**	**Psychiatric Residential Treatment Facility**	
04	***End Stage Renal Disease (ESRD) Center***		**09**	***Rural Health Clinic (RHC)***	
05	***Federal Qualified Health Center (FQHC)***		**10**	***Skilled Nursing Facility (SNF)***	

- ***In the block "Type of provider (M53)", enter the number from the above table that identifies the particular type of related or affiliated provide/supplier. Example: Enter the number "10" for a distinct part SNF or a collocated SNF related or affiliated.***

- ***In the block "Provider number (54)", enter the related or affiliated provider's Medicare provider number. In the case of PRTF, write the Medicaid provider number.***

Type of Provider (M53):_____ CCN (M54):_____

Type of Provider (M53):_____ CCN (M54):_____

Type of Provider (M53):_____ CCN (M54):_____

Type of Provider (M53):_____ CCN (M54):_____

Type of Provider (M53):_____ CCN (M54):_____

Type of Provider (M53):_____ CCN (M54):_____

Make additional copies as needed for additional related or affiliated provider numbers.